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- [Reserved for future use] (8)
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M. Female Reproductive System Conditions

- [Reserved for future use]
- (2) [Reserved for future use]
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- (3) Postpartum and Post Abortion Conditions Treated without Surgical Procedure

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Conditions Treated with Surgical Procedure

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- (2) [Reserved for future use]
- Red Blood Cell Disorders, (3) 395 Age > 17

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 - (2) Viral and Other Infection, 418-423
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- (6) [Reserved for future use]
- (7) [Reserved for future use]
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(2) (Age 0-17) 425, 427-429, 432 (3) (Age > 17) 425, 427-429, 432

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U. [Reserved for future use]

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	· · · · · · · · · · · · · · · · ·	
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EE. [Reserved for future use]		
FF. Depressive Neurosis (1) (Age 0-17) (2) (Age > 17)	426 426	
GG. Psychosis (1) (Age 0-17) (2) (Age > 17)	430 430	
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<pre>II. Operating Room Procedure Unrelated (1) [Reserved for future use] (2) Nonextensive (3) Extensive (Age 0-17) (4) Extensive (Age > 17)</pre>	to Principal 1 476, 477 468 468	Diagnosis
JJ. [Reserved for future use]		
<pre>KK. Extreme Immaturity (1) (Weight < 1500 Grams) (2) [Reserved for future use] (3) [Reserved for future use] (4) [Reserved for future use]</pre>	386 387	76501 to 76505 76500
(5) Neonate Respiratory Distress Syndrome	386	Codes in DRG 386 except 76501 to 76505
LL. Prematurity with Major Problems (1) (Weight < 1250 Grams) (2) (Weight 1250 to 1749 Grams)	387 387	76511 to 76514 76506, 76510 76515, 76516

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(3) (Weight > 1749 Grams)	387	Codes in DRG 387 except 76500, 76506, 76510 to 76516
MM. Prematurity without Major Problems	388	
NN. Full Term Neonates (1) With Major Problems (2) With Other Problems	389 390	
00. Multiple Significant Trauma	484-487	
PP. [Reserved for future use]		
QQ. Normal Newborns and Neonates who Died on the Day of Birth	391, 385	DRG 385 includes neonates who expire at the birth hospital, and discharge date is the same as the birth date
RRTT. [Reserved for future use]		

R

TTTT	Organ	Transplants
uu.	Organ	Transbrancs

- (1) [Reserved for future use]
- [Kidney, Pancreas, and Bone (2)

Heart, Lung, Liver, Bowel (3) Transplants

302, 481, 191, 292

103, 480, 495

DRG 191, 292 includes 52.80-52.86 only

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Bowel transplant includes any DRG with procedure 46.99 and Revenue Code 811 or 812

only

VV. [Reserved for future use]

WW. Human Immunodeficiency Virus 488-490

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C. Diagnostic categories relating to a rehabilitation hospital or a rehabilitation distinct part.

The following diagnostic categories are for services provided within a rehabilitation hospital or a rehabilitation distinct part, regardless of program eligibility:

DRG NUMBERS INTERNATIONAL DIAGNOSTIC WITHIN CLASSIFICATION OF CATEGORIES DIAGNOSTIC DISEASES, 9th Ed. CATEGORIES CLINICAL MODIFICATIONS A. Nervous System Diseases and Disorders 001-035 except codes in XX B.-G. [Reserved for future use] H. Diseases and Disorders of the Musculo-Skeletal System & Connective Tissues 209-213, except codes in XX 216- 220, 223- 256, 471, 491, 496-503 I.- QQ. [Reserved for future use] RR. Mental Diseases and Disorders/ Substance Use and Substance Induced Organic Mental Disorders 424-432, except codes in XX 434, 435 SS. Multiple Significant Trauma/ Unrelated Operating Room Procedures 468, 476, except codes in XX 477, 484-487 TT. Other Conditions Requiring Rehabilitation Services 036-208 except codes in XX 257-423, 439-455, 461-467, 472, 473,

475, 478-483,

488-490, 492-495, 504-511

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UU. [Reserved for future use]

VV-WW. [Reserved for future use]

XX. Quadriplegia and Quadriparesis Secondary to Spinal Cord Injury All DRGs

Includes all DRGs with ICD-9 diagnoses codes; 344.00-344.04, or 344.09 in combination with 907.2

76510 to 76516

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D. Diagnostic categories for neonatal transfers. The following diagnostic categories are for services provided to neonatal transfers at receiving hospitals with neonatal intensive care units, regardless of program eligibility:

DIAGNOSTIC CATEGORIES	DRG NUMBERS WITHIN DIAGNOSTIC CATEGORIES	•		
A JJ. [Reserved for future us	e]			
KK. Extreme Immaturity				
(1) (Weight < 750 Grams)		76501, 76502		
(2) (Weight 750 to 999 Grams)		76503		
(3) (Weight 1000 to 1499 Grams)	386, 387	76504, 76505 76500		
(4) [Reserved for future use](5) Neonate Respiratory Distress				
Syndrome Syndrome	386	Codes for DRG 386 except 76501 to 76505		
LL. Prematurity with Major Problems				
(1) (Weight < 1250 Grams)	387	76511, 76512, 76513, 76514		
(2) (Weight 1250 to 1749 Grams)	387	76506, 76510, 76515, 76516		
(3) (Weight 1250 to 1749 Grams)	387	Codes for DRG 387 except 76500, 76506,		

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MM. Prematurity without Major Problems
(Weight > 1749 Grams) 388

NN. Full Term Neonates

(1) With Major Problems (Age 0) 389

(2) With Other Problems 390

OO.-WW. [Reserved for future use]

E. Additional DRG requirements.

1. Version 17 of the Medicare grouper and DRG assignment to the diagnostic category must be used uniformly for all determinations of rates and payments.

- 2. The discharge status will be changed to "discharge to home" for DRG 433.
- 3. A diagnosis with the prefix "v57" will be excluded when grouping under all diagnostic categories under item C.
- 4. For neonates transferred to a neonatal intensive care unit with a DRG assignment of DRG 482 or DRG 483, the ICD-9-CM procedure codes 30.3, 30.4, 31.11, 31.21 and 31.29 will be excluded when grouping under items A and B.
- 5. The discharge status will be changed to "discharge to home" for all neonates in DRG 385, except for neonates who expire at the birth hospital and the discharge date is the same as the date of birth.
- 6. For payment of admissions that result from the unavailability of a home health nurse, and when physician orders from home remain in effect, the principal diagnosis will be identified at V58.89, Other Specified Procedures and Aftercare.
- 7. Payment for bowel transplants and pancreas transplants will be made only for admissions that result in the receiving a transplant during that admission.

Hospital cost index or HCI. "Hospital cost index" or "HCI" means the factor annually multiplied by the allowable base year operating cost to adjust for cost changes.

Inpatient hospital costs. "Inpatient hospital costs" means a hospital's base year inpatient hospital service costs determined allowable under the cost finding methods of Medicare but not to include the Medical Assistance hospital surcharge and without regard to adjustments in payments imposed by Medicare.

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Inpatient hospital service. "Inpatient hospital service" means a service provided by or under the supervision of a physician after a recipient's admission to a hospital and furnished in the hospital, including outpatient services provided by the same hospital that directly precede the admission.

Local trade area hospital. "Local trade area hospital" means a MSA hospital with 20 or more Medical Assistance (including General Assistance Medical Care, a State-funded program) admissions in the base year that is located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota.

Long-term care hospital. "Long-term care hospital" means a Minnesota hospital or a metropolitan statistical area hospital located outside Minnesota in a county contiguous to Minnesota that meets the requirements under Code of Federal Regulations, title 42, part 412, section 23(e).

Metropolitan statistical area hospital or MSA hospital. "Metropolitan statistical area hospital" or "MSA hospital" means a hospital located in a metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Non-metropolitan statistical area hospital or non-MSA hospital. "Non-metropolitan statistical area hospital" or "non-MSA hospital" means a Minnesota hospital not located in a metropolitan statistical area as determined by Medicare for the October 1 prior to the most current rebased rate year.

Operating costs. "Operating costs" means inpatient hospital costs excluding property costs.

Out-of-area hospital. "Out-of-area hospital" means a hospital that is located in a state other than Minnesota excluding MSA hospitals located in a county of the other state in which the county is contiguous to Minnesota.

Property costs. "Property costs" means inpatient hospital costs not subject to the hospital cost index, including depreciation, interest, rents and leases, property taxes, and property insurance.

Rate year. "Rate year" means a calendar year from January 1 through December 31.

Rehabilitation distinct part. "Rehabilitation distinct part" means inpatient hospital services that are provided by a hospital in a unit designated by Medicare as a rehabilitation distinct part.

Relative value. "Relative value" means the mean operating cost within a diagnostic category divided by the mean operating cost in all diagnostic categories within a program at diagnostic category A or B or specialty group C or D. The relative value is calculated from the total allowable operating costs of all admissions. This includes the full, untruncated costs of all exceptionally high cost or long stay admissions. Due to this inclusion of all costs, the relative value is composed of two parts. The basic

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unit of the relative value adjusts for the cost of an average admission within the given diagnostic category. The additional component of the relative value consists of an adjustment to compensate for the costs of exceptionally high cost admissions occurring within the diagnostic category. This factor, when applied to the base rate and the day outlier rate, cause additional payment adjustments to be made to compensate for cost outliers typically found within the diagnostic category. Since all cost is included, the cost outlier threshold is the average cost and is set to pay a cost outlier adjustment for all admissions with a cost that is above the average. The amount of payment adjustment to the operating rate increases as the cost of an admission increases above the average cost.

Seven-county metropolitan area hospital. "Seven-county metropolitan area hospital" means a Minnesota hospital located in one of the following counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, or Washington.

Transfer. "Transfer" means the movement of a recipient after admission from one hospital directly to another hospital with a different provider number or to or from a rehabilitation distinct part.

Trim point. "Trim point" means that number of inpatient days beyond which an admission is a day outlier.

SECTION 3.0 ESTABLISHMENT OF BASE YEARS

- A. The base year for the 1993 rate year shall be each Minnesota and local trade area hospital's most recent Medicare cost reporting period ending prior to September 1, 1988. If that cost reporting period is less than 12 months, it must be supplemented by information from the prior cost reporting period so that the base year is 12 months except for hospitals that closed during the base year.
- B. The base year data will be moved forward three years beginning with the 1995 rate year. The base year data will be moved forward every two years after 1995, except for 1997, or every one year if notice is provided at least six months prior to the rate year by the Department. For hospitals that open after April 1, 1995, the base year is the year for which the hospital first filed a Medicare cost report. That base year will remain until it falls within the same period as other hospitals.

SECTION 4.0 DETERMINATION OF RELATIVE VALUES OF THE DIAGNOSTIC **CATEGORIES**

4.01 Determination of relative values. The Department determines the relative values of the diagnostic categories as follows: